PRIMARY HEALTH CARE-COMMUNITY HEALTH CENTER
REQUEST FOR PROPOSAL
State Form 52633 *(*R/2-07)
INDIANA STATE DEPARTMENT OF HEALTH *(ISDH)*
Office of Primary Care *(OPC)* - Community Health Centers *(CHC)*
Form approved by State Board of Accounts, 2007

Page 1: Application Face Page

INDIANA STATE FISCAL YEAR 2008

FY 2008 Amount Requested: $ ____________ FY 2007 Amount Received: $ ____________

Legal Agency /Organization Name: ______________________________

Street	City	ZIP Code
Phone	Fax	E-Mail Address
Name of Agency Contact Person	Title of Contact Person	E-Mail Address

Proposed Service Area *(City, Counties)*: ______________________________

Please Check All that Apply: ☐ NEW APPLICANT *(not currently funded)*

☐ Private Nonprofit	☐ Federally Qualified Health Center	☐ Prenatal Care
☐ Medically Underserved Area	☐ Federally Qualified Health Center Look Alike	☐ Pediatric Care
☐ Medically Underserved Population	☐ Rural Health Clinic	☐ Post Partum Care
☐ Health Professional Shortage Area	☐ University Affiliated	☐ Newborn Care
☐ Dental HPSA	☐ School Based Only	☐ Family Planning
☐ Teaching Facility	☐ School Based and Community Health Center	☐ Adult Care

- -

Signature of Project Director *(type name)*	Phone
Signature of Board President/Chairperson *(type name)*	Phone
Signature of Project Medical Director *(type name)*	Phone
CEO/Official Custodian of Funds (*type name)*	Phone
(Optional) Signature of Local Health Officer *(type name)*	Date signed or notified

Signature of person authorized to make legal and contractual agreements for the applicant agency *(type name)*	Title	Date

Are you registered with the Secretary of State? ☐ Yes ☐ No

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Page 3 -Project Information

Name and address of all clinic locations.

Name ***all*** clinic sites Name of Clinic Manager Phone Number	Address of clinic site County	Supported by ISDH-OPC Funds
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No

Page 4 –Sources of Funding

List ***all*** sources of funding including other ISDH Programs *(e.g. OPC, Maternal Child Health Care Services, Newborn Screening, Preparedness, HIV/AIDS, WIC, etc.).*

Fiscal Year *(FY)* 2004-2005

Source of Funding *(Agency)*	Amount of Funding

FY 2005-2006

Source of Funding *(Agency)*	Amount of Funding

FY 2006-2007

Source of Funding *(Agency)*	Amount of Funding

What year did the applicant organization begin receiving ISDH-OPC Community Health Center Funding? _____ Amount: $ _____

Form A
Proposed Expenditures for State Fiscal Year 2008

Applicant Agency: _____

12-Month Budget Period: From July 1, 2007 to June 30, 2008

Category		Total Project Costs	CHC Request	Matching Funds	Percent of CHC Request from total Budget
A. TOTAL PERSONNEL	Salaries				
	Fringes				
B. OPERATING EXPENSES					
Contractual Services					
Equipment					
Consumable Supplies					
Pharmaceuticals					
Travel					
Rent and Utilities					
Communications					
Professional Staff CEU/CMEs					
Professional Staff Trainings					
ISDH Priorities *(non-clinical)* – Form G Only Related Items					
Other Expenditures					
SUBTOTAL B					
TOTAL					

Form A-2 - Sample Budget Narrative

This sample budget narrative is provided as a general outline. Providing additional information and detail is recommended to fully describe your proposal. Please mark pages A-2; A-2-a; A-2-b; A-2-c, etc.

REVENUE:

REVENUE TOTAL:

SALARIES:

PERSONNEL: *(Break out by Position)*

FRINGE BENEFITS: *(Itemize each segment of Fringe Benefits)*

PERSONNEL & FRINGE TOTAL:

TRAVEL: Itemize travel for patient care *(home visits, patients' transportation vouchers, gas cards, cab rides, etc.)*

TOTAL:

EQUIPMENT: New purchases, repairs or maintenance costs.

EQUIPMENT *(The following line items and dollar amounts are illustrative only. You may delete samples when you type in your info.)***:**

4 Exam Tables *(4 @ $3,000)*
1 Medical X-Ray *(1 @ $17,800)*
4 Dental Units *(4 @ $ 4,500)*
4 Dental Chairs *(4 @ $4,000)*
1 Dental X-Ray *(1 @ $10,200)*
8 Stools *(8 @ $250)*
20 Hand pieces *(20 @ $600)*
1 Developing Unit *(1 @ $2,000)*
8 PCs and related software *(8 @ 3,500)*

TOTAL ALL EQUIPMENT

SUPPLIES:

Office & Printing Supplies $ _____ per encounter
Medical & Dental Records $ _____ per encounter
Medical Supplies $ _____ per encounter
Pharmacy Supplies including Drugs
Average per number of Prescriptions
X-ray supplies Average per number of X-rays
Laboratory supplies per average number of procedures
Building and Maintenance Supplies per number of sites

TOTAL: SUPPLIES

CONTRACTUAL *(Please describe with enough detail to justify the costs.)*

Patient Care Contracts
- Outside Reference Lab
  - XYZ Company for any tests that cannot be performed in-house
  - *(Average number of procedures X Average Cost)*
- Outside Contract Pharmacies *(describe)*
  - *(Average number of prescriptions X Average Cost)*
- OB/GYN Contract with ABC Company
  - *(Average number of Patients served X Average Cost)*
- Ophthalmologist with RST Company
  - *(Average number of patients @ Average Cost)*
- Temporary Nursing Coverage
  - *(Average number of days @ Average Costs)*

Subtotal: Patient Care Contracts

Non-Patient Contracts
- Housekeeping Services with LMN Company
  - Number of sites
- Security Services with DEF Company for
  - Number of hours per site
- Computer Maintenance Contract
- Landscaping Services

Subtotal: Non-Patient Contracts

TOTAL: CONTRACTUAL

OTHER:

Payroll Processing Services
Audit Services with JKL Company
Legal Fees with WXY Company fee per hour
Association Dues
Building Contents Insurance
Telephone Service
Answering Services
Postage
Utilities
Rent *(describe per site)*
Marketing/Outreach
Educational materials
Any special taxes *(describe)*
Technical Assistance

TOTAL: OTHER

BUDGET TOTAL:

Form B – Personnel

List personnel for each clinic site.

***** ***List the number of hours considered Full Time Equivalent (FTE) by applicant:***

NAME AND POSITION/TITLE SITE/CLINIC LOCATION SITE/CLINIC HOURS OPEN FOR PATIENT CARE	ANNUAL SALARY	NUMBER OF MONTHS FOR BUDGET	PERCENTAGE TIME	TOTAL FUNDS REQUESTED
	(1)	*(2)*	*(3)*	*(4)*
	$		%	$
Clinical - MDs				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours : ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				
On – site ☐ Clinical ☐Number of hours: ☐Consultant ☐On Call				

Form B-2- Personnel *(continued)*

List clinical personnel for each clinic site.

NAME AND POSITION/ TITLE TYPE OF CLINICIAN *(NP, RN, LPN, CMA, DDS, etc.)* SITE LOCATION	ANNUAL SALARY	NUMBER OF MONTHS FOR BUDGET	PERCENTAGE TIME	TOTAL FUNDS REQUESTED
	(1)	*(2)*	*(3)*	*(4)*
	$		*%*	$
CHC Clinical Staff (NP, RN, LPN,CMA, DDS, RDH, and DA only)				

Form B-3- Personnel *(continued) List subsequent pages B-4-; B-5-; B-6-, etc*

List administrative personnel for each clinic site.

NAME AND POSITION/ TITLE SITE LOCATION	ANNUAL SALARY	NUMBER OF MONTHS FOR BUDGET	PERCENTAGE TIME	TOTAL FUNDS REQUESTED
	(1)	*(2)*	*(3)*	*(4)*
	$		%	$
CHC Other Staff				

Form C - Professional Licenses *List subsequent pages Form C-2; C-3; C-4; etc.*

List staff with current professional licenses.

Name of staff person	Type of License

Form D - Board Members

Applicants must meet the community health center criterion of 30 percent consumer based Board.

Type of Board: ☐ Board of Directors ☐ Advisory Board

How often does the Board meet:

When does the Board meet *(day and time)*:

Name	**Address**	**Phone**	**E-mail**	**Profession**	**CHC Consumer** **Yes or No**	**Position on Board**	**Board Position Term Length**	**Years in Position**

Form D-2- Board Members *(continued)*

Applicants must meet the community health center criterion of 30 percent consumer based Board.

Name	Address	Phone	E-mail	Profession	CHC Consumer Yes or No	Position on Board	Board Position Term Length	Years in Position

Form E– Monthly Report Totals for Calendar Year 2004

OMB No.: 0915-0285. Expiration Date: 06/30/2007

OFFICE OF PRIMARY CARE: State Funded Community Health Center Annual Report – **Calendar Year 2004**

Name of Center: City:
Name of Preparer: Phone Number: Email:

By Age	Total New Patients by Gender * M	F		Existing Patients of Record	Medical Service Provided	Dental Service Provided	White, non Hispanic	Black, non Hispanic	Hispanic or Latino	American Indian/Alaska Native	Asian/Pacific Islander	Unreported/ Refused to report
Birth-18												
19-64												
Over 65												
Totals												

Total Encounters this YEAR by payer source:

By Age	Medicaid	Hoosier Healthwise	Medicare	Private Insurance	Sliding Fee Scale		Chronic Disease Patients	New Diagnosis	Number of active patients this year
Birth – 18							Diabetes		
19-64							Cardiovascular		
Over 65							Depression		
Total							Asthma		
							Other		

Form E -2 – Monthly Report Totals for Calendar Year 2005

OFFICE OF PRIMARY CARE: State Funded Community Health Center Annual Report – **Calendar Year 2005**

Name of Center: City:
Name of Preparer: Phone Number: Email:

By Age	Total New Patients by Gender * M	F		Existing Patients of Record	Medical Service Provided	Dental Service Provided	White, non Hispanic	Black, non Hispanic	Hispanic or Latino	American Indian/Alaska Native	Asian/Pacific Islander	Unreported/ Refused to report
Birth-18												
19-64												
Over 65												
Totals												

Total Encounters this YEAR by payer source:

By Age	Medicaid	Hoosier Healthwise	Medicare	Private Insurance	Sliding Fee Scale		Chronic Disease Patients	New Diagnosis	Number of active patients this year
Birth – 18							Diabetes		
19-64							Cardiovascular		
Over 65							Depression		
Total							Asthma		
							Other		

Form E-3 – Monthly Report Totals for Calendar Year 2006

OFFICE OF PRIMARY CARE: State Funded Community Health Center Annual Report – **Calendar Year 2006**

Name of Center: City:
Name of Preparer: Phone Number: Email:

By Age	Total New Patients by Gender * M	F		Existing Patients of Record	Medical Service Provided	Dental Service Provided	White, non Hispanic	Black, non Hispanic	Hispanic or Latino	American Indian/Alaska Native	Asian/Pacific Islander	Unreported/ Refused to report
Birth-18												
19-64												
Over 65												
Totals												

Total Encounters this YEAR by payer source:

By Age	Medicaid	Hoosier Healthwise	Medicare	Private Insurance	Sliding Fee Scale		Chronic Disease Patients	New Diagnosis	Number of active patients this year
Birth – 18							Diabetes		
19-64							Cardiovascular		
Over 65							Depression		
Total							Asthma		
							Other		

Form F - ISDH Priorities:

Priority Health Initiatives:

Please write no more than one page for each Priority Health Initiative describing what the CHC is doing now to meet these objective and in the future.

Data driven efforts for both health conditions and health systems initiatives

- Effective, efficient, and timely data collection
- Data-driven policy-making
- Evidence-based and results-oriented programming
- Informatics: integrated and linked medical with public health records

INShape Indiana

- Agency-wide promotion of prevention and individual responsibility, especially in the areas of obesity prevention through good nutrition, exercise and tobacco use cessation.
- Engage all components of communities – collaborative partners.
- Integrate INShape Indiana opportunities in all programming and communications.

Integration of medical care with public health

- Medicaid medical policy that values public health principles
- Appropriately targeted access to care for underserved Hoosiers
- Opportunities for Medicaid demonstration projects to showcase successful public health-based interventions
- If not a Medicare/Medicaid provider, explain your application process or why not.

Preparedness

- Continual scanning for developing public health threats regardless of cause of the threat.
- Planning and training for poised and effective response to threats that cannot be prevented.
- Collaboration with the Local Public Health Coordinator and community agencies.

Form F 1 - ISDH Priorities:

Please write one page or less describing what the CHC is doing now and in the future.

<u>Priority Health Initiative:</u> Data driven efforts for both health conditions and health systems initiatives. Discuss how you are developing or expanding data-driven, policy making, collection and integrating informatics into your CHC operations.

Form F 2 - ISDH Priorities:

Please write one page describing what the CHC is doing to meet this initiative with the patient and staff now and in the future.

<u>Priority Health Initiative</u>: INShape Indiana. Discuss collaborative efforts for good nutrition, obesity treatment, tobacco cessation and development of fitness programs.

Form F 3 - ISDH Priorities:

Please write one page or less describing what the CHC is doing to meet this initiative now and in the future.

<u>Priority Health Initiative:</u> Integration of medical care with public health. Discuss medical model, community needs, patient diseases, Medicaid participation and barriers to success.

Form F 4 - ISDH Priorities:

Please write one page describing what the CHC is doing to meet this initiative now and in the future.

<u>Priority Health Initiative</u>: Preparedness. Discuss collaboration, planning, training and future development of response activities.

Form G – Program Narrative *(List subsequent pages Form G-2; G-3; etc.)*

Form H –Expansions *(Two page limit.)*

Form I – SLIDING FEE SCHEDULE *(Provide the applicant organization's sliding fee schedule.)*

Appendix A –Performance Measures

Provider Name:

CHC Performance Measure 1: Proportion of low birth-weight births.

	SFY 2005	***SFY 2006***	***SFY 2007***	***SFY 2008***	***HP 2010***
Annual Performance Objective: Reduce the percent of low birth-weight infants among all live births to:	%	%	%	%	**5** %
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	
Numerator (N): # of live births in Project with birth weight < 2500 grams					
Denominator (D): # of live births in Project to women seen through 32 weeks who had at least 3 visits					

(For Semiannual and Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:**

Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***
1. 100% of all prenatal clients will receive preterm labor education at 20-24 weeks.	Min. chart audit (10 charts)	1. Chart audit			
2. 100% of clients will be educated in appropriate weight gain at first visit.	Chart Audit for documented weight gain grid at first visit and each visit thereafter	Weight gain grid and chart documentation.			
3. Semi annual review of all LBW births and neonatal deaths	LBW and Infant Death Screening tool will be used for review with summary of improvements to be made.	Documentation of LBW and neonatal deaths reviewed twice a year.			

Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***

Provider Name:

CHC Performance Measure 2: Proportion of children who have completed age appropriate immunizations by age 3.

	SFY 2005	*SFY 2006*	*SFY 2007*	*SFY 2008*	*HP2010*
Annual Performance Objective: Increase the percent of two-year-olds who have received the full schedule of age-appropriate immunizations to:	%	%	%	%	**80** %
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	
Numerator (N): # of two-year-olds in Project who received full schedule of immunizations by their 3rd birthday					
Denominator (D): # of children in Project who were seen more than 1 time during the fiscal year who were enrolled before 18 months of age, and were 24-35 months of age on the last day of fiscal year					

(For Semiannual and Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:**

Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***
1. ≥ 90% of children who are on a delayed immunization schedule will be identified, provided with an immunization, or referred to provider for immunization.	1. Documentation of clinic procedure for identifying, and providing services. 2. Chart documentation.	1. Written clinic procedure. 2.Chart audit			

Provider Name:

CHC Performance Measure 3: Proportion of clients who reduced or stopped smoking/tobacco use.

	SFY 2005	***SFY 2006***	***SFY 2007***	***SFY 2008***	***HP2010***
Annual Performance Objective: Increase the percent of clients served by CHC who reduce or stop smoking/tobacco use to:	%	%	%	%	**NA**
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve or baseline.)	%	%	%	%	
Numerator (N): # of clients served by Project who smoked/used tobacco at the initial visit who reduced or stopped tobacco by last trimester or last visit.					
Denominator (D): # of clients served by Project who smoked/used tobacco at the initial visit for: **1. Prenatal Care -** and were seen through 32 weeks of pregnancy, received at least 3 visits and delivered; or **2. Primary Care -** for at least two visits during the year. **3. Dental Care-** for every visit conducted.					

(For Semiannual and Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:**

Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***
1. 100% of clients will be asked if they use tobacco at the initial visit. (Charts should be flagged if clients are identified as smokers/users.)	1.Chart documentation	1.Chart audit			
2. ____% identified as smokers/users will have tobacco use status documented at every visit.	1.Chart documentation	1.Chart audit			
3. ____% identified as smokers/users who were helped onsite or referred to a cessation program, off premises.	1. Chart documentation	1.Chart audit			

Provider Name:

CHC Performance Measure 4: Proportion of Adults receiving Hemoglobin A1c Measurement

	SFY 2005	***SFY 2006***	***SFY 2007***	***SFY 2008***	***HP2010***
Annual Performance Objective: Increase percentage of adults with diabetes who had a Hemoglobin A1c measurement at least once in the past state fiscal year.	%	%	%	%	%
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	
Numerator (N): # of diabetic patients with at least one visit to Project who had at least one hemoglobin A1c measurement taken during the past state fiscal year.					
Denominator (D): # of unduplicated diabetics seen by the Project at least once during the past state fiscal year.					

(For Semiannual and Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:**

Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***
Flag charts of all diabetic patients.	Chart Audit	Chart Audit			
Develop a protocol for obtaining hemoglobin A1c for each diabetic.					
Implement protocol.					

Provider Name:

CHC Performance Measure 5: Percentage of adults with Diabetes who received influenza immunization.

	SFY 2005	***SFY 2006***	***SFY 2007***	***SFY 2008***	***HP2010***
Annual Performance Objective: Increase the number of adult diabetic patients who received an influenza immunization.	%	%	%	%	%
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	
Numerator (N): # of adult diabetic patients with at least one visit during the state fiscal year who received an influenza immunization.					
Denominator (D): # of adult patients with at least one visit during the state fiscal year.					

(For Semiannual and Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:**

Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***
100% of adult diabetic patients with at least one visit during influenza immunization period will receive influenza immunization during the state fiscal year.	Chart Audit	Chart Audit			
All diabetic patients will receive a reminder to come in for immunization before the influenza season.					

Provider Name:

CHC Performance Measure 6: Proportion of Adults whose Blood Pressure is checked and Proportion of Adults whose Blood Pressures are ≤ 130 mm Hg systolic or ≤ 80 mm Hg diastolic.

	SFY 2005	***SFY 2006***	***SFY 2007***	***SFY 2008***	***HP2010***
Annual Performance Objective: Increase the number of adults whose blood pressures are < 130mm Hg systolic or < 80 mm Hg diastolic.	%	%	%	%	%
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	
Numerator (N): # of adult patients who visit the Project and have a blood pressure check.					
Denominator (D): # of adult patients who visit the Project.					
Numerator (N): # of adult patients who visit the Project at least twice, whose most recent blood pressure check was < 130 mm Hg/ < 80 mm Hg.					
Denominator (D): # of adult patients who visit the Project at least twice.					
Numerator (N): # of adult/teen patients served by the Dental Clinic who have a blood pressure check..					
Denominator (D): # of adult/teen patients served by the Dental Clinic.					
Numerator (N) # of adult/teen dental patients whose blood pressures are > 120 Hg systolic or > 80 mm Hg diastolic, who are referred to their physicians.					
Denominator (D) # of adult/teen dental patients who had blood pressures taken.					

(For Semiannual and Annual Report use only)

PERFORMANCE OBJECTIVE MET: ☐ YES ☐ NO DATA SOURCE:					
Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***
All adults will receive a blood pressure check every visit, unless reason for skipping procedure is noted in chart.	Chart blood pressures.	Chart Audit			
Charts of patients with blood pressures ≥ 120 mm Hg/ 80 mm Hg are identified to be followed.	Charts of patients with high blood pressures will be marked so staff can readily identify them.	Chart Audit.			
Lifestyle modifications (weight control, physical activity, alcohol moderation, moderate sodium restrictions, and emphasis on consumption of fruits and vegetables and low-fat dairy products) will be initiated with all patients whose blood pressure measures ≥ 120 mm Hg/80 mm Hg (as per AHA/ACC Secondary Prevention Guidelines).	Lifestyle modification education will be charted when given.	Chart audit.			
Follow AHA Guidelines for Primary Prevention of Cardiovascular Disease and Stroke: 2002 Update. Follow AHA/ACC Guidelines Secondary Prevention for Patients with Coronary and Other Vascular Disease: 2001 Update.	Record in chart the guidelines that are being followed.	Chart Audit			

Provider Name:

CHC Performance Measure 7a: Check BMI of all Adults and Identify the Proportion of Adult Patients who's BMIs are ≥ 25.

	SFY 2005	*SFY 2006*	*SFY 2007*	*SFY 2008*	*HP 2010*
Annual Performance Objective: Determine the baseline or reduce the percent of adult patients whose BMIs are ≥ 25 to:	%	%	%	%	15%
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	
Numerator (N): # of adult patients whose BMIs are ≥ 25					
Denominator (D): # of adult patients					
Numerator (N): # of adult patients whose BMIs are ≥ 25 - <29					
Denominator (D): _____# of adult patients					
Numerator (N): # of adult patients whose BMIs are ≥ 29					
Denominator (D): # of adult patients					

(For Semiannual and Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:**

Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***
1. 100% of all charts of patients with BMI of 25 or greater will be identified for follow-up.	Min. chart audit (10 charts)	1. Chart audit			
2. 100% of clients with BMI of 25 – 29.9, (classified as overweight), or with a BMI of 30 or greater (classified as obese) will be provided intervention or given appropriate community referrals.	Chart Audit for documented patients	1. Chart audit			

Work Plan Measurable Activities	How will activities be measured or demonstrated?	What documentation is used to measure?	Adjustments in work plan	*Problems*	*Staff Responsible*

Provider Name:

CHC Performance Measure 7b: Check BMI of all Children and Identify the Proportion of Overweight or Obese Child Patients.

	SFY 2005	*SFY 2006*	*SFY 2007*	*SFY 2008*	*HP 2010*
Annual Performance Objective: Determine the baseline or reduce the percent of overweight/obese child patients to:	%	%	%	%	5%
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	
Numerator (N): # of child patients whose BMI is calculated.					
Denominator (D): # of child patients					
Numerator (N): # of child patients whose BMI is ≥ than 85%ile.					
Denominator (D): # of child patients					

(For Semiannual and Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:**

Work Plan Measurable Activities	How will activities be measured or demonstrated?	What documentation is used to measure?	Adjustments in work plan	*Problems*	*Staff Responsible*
1. 100% of child patients will be weighed and measured and a BMI calculated and plotted.	Growth Chart will be a part of the chart and plotted at each visit.	1. Chart audit.			
2. 100% of all charts of child patients	Min. chart audit (10 charts)	1. Chart audit			

Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***
with BMI determined by the CDC child protocols as overweight or obese will be identified for follow-up.					
3. 100% of clients with BMI determined by the CDC child protocols as overweight or obese will be provided intervention or given appropriate community referrals.	Chart Audit for documented patients	1. Chart audit			

Provider Name:

CHC Performance Measure 8: Performance Measures of Your Choice (optional)

	SFY 2005	*SFY 2006*	*SFY 2007*	*SFY 2008*	*HP2010*
Annual Performance Objective:	%	%	%	%	**NA**
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve or baseline.)	%	%	%	%	
Annual Outcome Objective					
Annual Outcome Indicator (N/D-U) x 100)					

Numerator (N):

Denominator (D)

Unknown (U)

(For Semiannual and Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:**

Work Plan Measurable Activities	**How will activities be measured or demonstrated?**	**What documentation is used to measure?**	**Adjustments in work plan**	***Problems***	***Staff Responsible***

Appendix B – CHC REQUIREMENTS CHECKLIST

(Check the appropriate box)

General Requirements

Yes☐ No ☐ Established need as determined by the number of uninsured/underinsured patients who require comprehensive, prevention-oriented primary health care at a health care home.

Yes☐ No☐ Access to primary health care in health professional shortage areas *(HPSA)*, health professional shortage area populations *(HPSA-POP)*, medically underserved areas *(MUA)*, medically underserved populations *(MUP)* or other special populations. Special populations may include migrant and seasonal farm workers, the homeless, HIV-AIDS patients, ethnic minorities, the elderly, pregnant women, and others with special health needs and/or geographic, cultural and economic barriers to care.

Yes☐ No☐ Sites are expected to make an effort to extend services and promote appropriate utilization of prevention services regardless of patients' age, gender or ability to pay. **No one should be refused services**.

Yes☐ No☐ Sites shall have an adjusted fee schedule policy that is available, printed and posted so those who need to take advantage of it may do so.

Yes☐ No☐ Chart and documentation of service delivery for each patient shall be maintained.

Yes☐ No☐ OSHA basic requirements for a workplace will be met.

Yes☐ No☐ Sites shall be willing to participate in health professionals training programs.

Yes☐ No☐ Administrative documents to include mission statement, by-laws, Affirmative Action policy, list of contracts and leases, hours of operation, and proof of liability insurance will be on file.

Staffing Requirements

Yes☐ No☐ While projects may utilize several part-time staff, there should be at least one full-time physician or nurse practitioner with prescriptive authority available on-site at least 20 hours per week to provide consistency and care continuity.

Yes ☐No☐ Sites must demonstrate that all providers are licensed to practice in Indiana. Board certification or eligibility is preferred for physicians. Nurse practitioners and physician assistants must be nationally certified. Credentials must be current and in the individuals' personnel files.

Yes☐ No☐ Sites should have, at a minimum, one physician or Nurse Practitioner on-site at least 20 hours per week that has hospital admitting privileges to the nearest local hospital.

Appendix B – 2 – CHC REQUIREMENTS CHECKLIST

Yes☐ No☐ All patients should have 24-hour access to providers affiliated with their health care home. Twenty-four hour coverage may be arranged through shared call among the health center's employed providers or through shared call among a broader group of providers through formal arrangement. Phone answering services that refer patients automatically to the nearest emergency room are not acceptable.

Yes☐ No☐ Accommodation of patients who are unable to access a site's providers during regular business hours, sites should provide flexible hours to meet the need of the community without sacrificing popular week-day service hours.

Yes☐ No☐ Efficiency standards shall be maintained for staff with direct patient involvement including: CPR certification based on current American Heart Association standards; demonstration of basic medical & nursing skills competency for licensure and certification; special certifications for ALS, EKG, and lab skills; and job descriptions for all staff.

Yes☐ No☐ Sites shall maintain on file an organizational chart of health professional staff, administrative staff, subcontractors, volunteers, etc. who provide services and administer other aspects of the center's operations.

Yes☐ No☐ Sites shall maintain on file a list of staff positions indicating full-time equivalencies of those positions that provide and administer primary care services.

Yes☐ No☐ Educational and retraining opportunities should be in place to promote continuous quality improvement.

Yes☐ No☐ State criminal background checks as appropriate at time of hire, personnel policies and procedures, and liability policies shall be in place.

<u>Practice Guidelines</u>

Yes☐ No☐ Sites shall make use of local best practices for protocol development

Yes☐ No☐ Sites shall participate in the local health system including referral systems for local specialists, local primary care providers and hospitals; mental health providers; dental health providers; emergency services provisions; and coordination and referral with public health programs (e.g. WIC, EPSDT, family planning, HIV, immunization and communicable disease).

Yes☐ No☐ Sites shall have in place written practice guidelines or a process in place for evaluation of service delivery and outsource service arrangements.

Yes☐ No☐ Sites shall have in place written practice guidelines for mid-level practitioners.

Appendix B – 3 – CHC REQUIREMENTS CHECKLIST

Facility Requirements

Yes☐ No☐ The facility and layout shall accommodate projected patient volumes and facilitate efficient patient flow to the best of its ability.

Yes☐ No☐ The entrance to the facility shall indicate it is smoke-free through use of the universal symbol for non-smoking, as well as posting signboards throughout the facility.

Yes☐ No☐ The facility shall be handicap accessible, including parking spaces, entrances, restrooms, etc., that are marked appropriately.

Yes☐ No☐ Adequate space will be met according to Department of Health and Human Services/Bureau of Primary Health Care for examination rooms, lab space, record retention, waiting area, etc. OSHA requirements will be met for biohazard materials.

Yes☐ No☐ Facility hours of operation will be posted so they are visible from outside the building, as well as the after-hours phone number.

Equipment/Supplies

Yes☐ No☐ Inventories, warranties, service and maintenance agreements shall be kept on file.

Yes☐ No☐ Sites shall submit an annual inventory of equipment purchased with State CHC funds costing over $500.00, and shall maintain records of all prior written approvals obtained for such equipment.

Yes☐ No☐ Title to all property acquired with State funds by the grantee under the contract remains with the ISDH. These records will be subject to audit and/or inspections, as provided by law.

Community Participation/Collaboration

Yes☐ No☐ All sites should participate in collaborative efforts with residents, other public and private health care services, community groups, and agencies in their delivery of primary health care services. Collaborative efforts should be designed to avoid duplication and improve integration of local health services.

Yes☐ No☐ All sites should actively solicit financial assistance from the communities that the CHC operates within.

Yes☐ No☐ Memorandum of Agreement *(MOA)* /Memorandum of Understanding *(MOU)* of collaboration with other health care providers, health and human service agencies, government agencies are kept on file.

Appendix B – 4 – CHC REQUIREMENTS CHECKLIST

Components of Comprehensive Primary Care

Yes☐ No☐ A list of services provided on-site and through arrangements shall be on file at the site. *(Sites are not expected to be able to provide the full range of primary health care services.)*

Yes☐ No☐ Primary health care services by physicians and/or mid-level practitioners including treatment for acute disease and management of chronic disease

Yes☐ No☐ Preventive health services

Yes☐ No☐ Case management and outreach

Yes☐ No☐ Basic diagnostic laboratory services

Yes☐ No☐ Pharmacy services needed to complete treatment

Yes☐ No☐ Referrals to supplemental service providers

Yes☐ No☐ Health education and counseling

Yes☐ No☐ Diagnostic X-ray services

Yes☐ No☐ Cultural competence employing an understanding of emotional and social factors in assessment and intervention for each individual client

Yes☐ No☐ Preventive dental

Yes☐ No☐ Optometric/Eye care

Yes☐ No☐ Emergency services

Yes☐ No☐ Services often essential to maintain or regain health

Yes☐ No☐ Restorative dental services

Yes☐ No☐ Services required ensuring access

Yes☐ No☐ Transportation for patients who would otherwise lack access to care

Yes☐ No☐ Translation services or bilingual staff

Appendix B – 5 – CHC REQUIREMENTS CHECKLIST

Governance

Yes☐ No☐ There will be a local governing board of 9-25 members which are representative of the community and which will include at a minimum one third consumers of the health care site *(51 percent, if the site is a FQHC)*. A governing board has responsibility for reviewing and approving decisions regarding budgets, scope of services, hours of operation, payment policies and procedures, and staffing. A list of current board members and user status shall be on file.

Yes☐ No☐ The local governing board will meet at a minimum 4 times per year. This will be documented and kept on file for review.

Yes☐ No☐ The highest ranking paid employee of the organization will be responsible for supplying the governing board with current financials on each CHC operating budgets at each board meeting. This will be documented and kept on file for review.

Quality Improvement Systems

Yes☐ No☐ Sites shall maintain on file the site's ongoing quality improvement program, including provider performance, protocols, and chart audits. As appropriate, it should describe how the quality improvement program relates to Health plan Employer Data and Information Set or other managed care quality improvement programs.

Yes☐ No☐ Sites shall maintain on file a complete set of administrative and clinical policies and procedures. A review process for policies and procedures shall be kept on file.

Yes☐ No☐ Sites shall conduct chart audits on a regular basis as part of their quality improvement plan. The procedure for data collection and the results of chart audits shall be kept on file.

Yes☐ No☐ Each facility shall have a written quality improvement process. The quality improvement process needs to make a critical examination of the clinical practice habits of the physician/mid-level practitioner staff. The review needs to consider professional knowledge, accuracy of diagnostic skills, appropriate therapies, appropriate consultations, competent decision-making and malpractice judgments–settled or pending.

Yes☐ No☐ Sites shall maintain on file copies of patient satisfaction surveys, as well as documentation of how often these surveys are conducted and how the information is utilized.

Yes☐ No☐ Sites shall have a written disaster preparedness plan.

Yes☐ No☐ Sites shall have a written plan for coordination, referral and appropriate utilization of local hospital emergency room services.

Appendix B – 6 – CHC REQUIREMENTS CHECKLIST

Ancillary Arrangement

Yes☐ No☐ For those primary health care services not provided on-site, MOAs/MOUs or contracts shall be on file documenting that referral arrangements are in place which ensure continuity of care.

Financial Management

Yes☐ No☐ Sites shall have billing and collection procedures in place to maximize revenues as appropriate through patient fees on an adjusted fee schedule, through billing to third party insurers such as Medicaid, Medicare, and private insurance. Sites shall be Medicaid and Medicare providers, or at a minimum have filed their application to be a Medicaid/Medicare provider.

Yes☐ No☐ Sites will bill Medicaid and Medicare.

Yes☐ No☐ Sites shall be willing to participate in Medicaid Managed Care as primary medical providers.

Yes☐ No☐ Sites are required to have an adjusted fee schedule for patients.

Yes☐ No☐ Sites shall have a business plan in place for maximizing self-sufficiency. The business plan shall demonstrate community support, including direct financial support and in-kind materials and services from other sources such as the local hospital, the city or township, and other local and public sources.

MIS System

Yes☐ No☐ Sites shall have a financial management system in place for billing, accounting, budget, management, and other systems to maximize patient-generated revenues. Sites shall demonstrate fiscal integrity by having accounting and internal control systems appropriate to the size and complexity of the organization.

Yes☐ No☐ Sites shall have a system which accurately collects and organizes data for reporting and which supports management decision-making, ideally integrating demographic, clinical, utilization, and financial information to reflect the operations and status of the organization as a whole.

Appendix B – 7 – CHC REQUIREMENTS PLAN *(For each "No" response, please identify by page number and explain in no more than three sentences.)*

ADDITIONAL COMMENTS FOR REVIEWERS